	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			SURVEY PLETED
		003563	B. WING		01	R / 04/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
HEALTHS	ET		HEBRON AVE /ILLE, IN 47714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{N 000}	Initial Comments		{N 000}			
	This was a revisit for survey completed on & 9-18-15.	the State re-licensure 9-15-15, 9-16-15, 9-17-15,				
	Survey Date: 1-4-16 Facility #: 003563					
	Medicare Provider #:	15-7559				
	Medicaid Vendor #: 2	200450280				
	Census: 4 skilled pat 3 home hea 7 total patie	alth aide only patients				
{N 504}	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights	{N 504}			
	his or her rights as a pagency as follows: (2) The patient has (D) Be informed about and of any changes in follows:	will furnish care; and				
	failed to ensure patien frequency of skilled no	ew and interview, the agency nts had been informed of the ursing and home health aide furnished in 3 (#s 1, 2, and				

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Indiana State Department of Health

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		003563			01/04/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA EBRON AVE	TE, ZIP CODE		
HEALTHS	ET		LLE, IN 47714			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
{N 504}	Continued From page	e 1	{N 504}			
	Authorization", signed parent on 9-30-15, the would be provided 3 shealth aide services week. The authorizat patient's parent had be frequency of skilled in physician. The record include by the physician for the transing had been ord week, 3 times per week week for 3 weeks, and week.	ed a plan of care established the certification period that evidenced skilled lered 2 times per week for 1 lek for 4 weeks, 2 times per d 3 times per week for 1				
	2. Clinical record number 2 included a "Patient Authorization" signed and dated by the patient on 12-16-15. The authorization failed to evidence the frequency of home health aide visits to be provided.					
	by the physician for the state of the services had been for 1 week 8 times per services.	ed a plan of care established the certification period that evidenced home health the en ordered 5 times per week the er week for 1 week, 4 times and 6 times per week for 6				
	Authorization" signed 10-22-15. The authonursing would be pro	mber 3 included a "Patient and dated by the patient on rization indicated skilled vided 3 times per week, vices 2 times per week, and es 1 time per week.				

Indiana State Department of Health

STATE FORM 6899 CA5Q12 If continuation sheet 2 of 20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 501251110.		
		003563	B. WING		R 01/04/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
HEALTHS	ET		EBRON AVE		
			LLE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{N 504}	Continued From page	2	{N 504}		
	established by the ph period 10-22-15 to 12 skilled nursing had be for 1 week, 3 times per times per week for 5 vevidenced home heal ordered 1 time per we per week for 8 weeks B. The record inclustablished by the ph period 12-21-15 to -10 nursing had been ord weeks and 3 times per 4. The Administrator additional documenta when asked on 1-4-10 states, "Client in advance of the skilled for the period 12-21 to -10 nursing had been ord weeks and 3 times per 4. The Administrator additional documenta when asked on 1-4-10 states, "Client in advance of the skilled for the period 11-17 states, "Client in advance of the skilled for the period 10-22-15 to -10 nursing had been ord weeks and 3 times per 4. The Administrator additional documenta when asked on 1-4-10 number II-17 states, "Client in advance of the period 10-22-15 to -10 nursing had been ord weeks and 3 times per 4.	luded a plan of care ysician for the certification 8-15 that evidenced skilled ered 2 times per week for 2 er week for 7 weeks. was unable to provide any tion and/or information			
{N 522}	410 IAC 17-13-1(a) P	ratient Care	{N 522}		
	written medical plan of periodically reviewed	edical care shall follow a of care established and by the physician, dentist, rist or podiatrist, as follows:			
	failed to ensure medic	t as evidenced by: ew and interview, the agency cations, treatments, and ovided as ordered by the			

Indiana State Department of Health

STATE FORM 6899 CA5Q12 If continuation sheet 3 of 20

Indiana State Department of Health

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			D. WING		R
		003563	B. WING		01/04/2016
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
HEALTHS	ET		EBRON AVE LLE, IN 47714		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	ION (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
{N 522}	Continued From page	e 3	{N 522}		
	physician in 3 (#s 1, 2 reviewed.	2, and 3) of 3 records			
	The findings include:				
	as a 14 year old pedia Syndrome, a genetic parts of the body, incl failed to evidence me had been administere physician on the plan included a plan of car physician for the certi 1-15-16. The plan of nurse] to instruct PCC administer Benadryl 2 G-tube [gastrostomy to infusion. SN to app Emla cream [numbing cream one hour prior flush IV [intravenous] NaCI [sodium chloride infusion then flush line.	of care. The record re established by the fication period 11-17-15 to care states, "SN [skilled G [patient caregiver] to			
	the Benadryl and nun administered at 3:05 been accessed at 3:3	dated 11-20-15 evidenced nbing cream had been PM and that the port had 5 PM. The SN failed to cream had been applied 1 ng the port per the			
	the Benadryl and nun administered at 4:35 accessed at 5:10 PM	dated 11-25-15 evidenced nbing cream had been PM and the port had been . The SN failed to ensure ad been applied 1 hour prior			

Indiana State Department of Health

STATE FORM 6899 CA5Q12 If continuation sheet 4 of 20

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
74401 2744	or dorace mon	IBENTII IOMITON NOMBER.	A. BUILDING: _		
		003563	B. WING		R 01/04/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HEALTHS	ET		EBRON AVE LE, IN 47714		
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{N 522}	Continued From page	2 4	{N 522}		
	to accessing the port	per the physician's order.			
	been flushed after the completed in accorda order. The note state [9:50 PM]. Flushed w deaccessed at 2151." evidence the IV line h saline per the physicial C. A SN visit note the Benadryl and numadministered at 4:20 I 4:55 PM. The SN fail cream had been applithe port.	nce with the physician's is, "Infusion finished at 2150 with 5 ml heparin port The note failed to had been flushed with normal an's orders. dated 12-1-15 evidenced hing cream had been PM and the port accessed at hed to ensure the numbing hied 1 hour prior to accessing			
	the Benadryl and num administered at 3:35 l 4:05 PM. The SN fail	dated 12-8-15 evidenced nbing cream had been PM and the port accessed at ed to ensure the numbing ied 1 hour prior to accessing			
	been flushed after the	to evidence the IV line had e infusion had been nce with physician orders.			
	the Benadryl and num administered at 4:55 l 5:35 PM. The SN fail	dated 12-15-15 evidenced hbing cream had been PM and port accessed at led to ensure the numbing lied 1 hour prior to accessing			
	been flushed with nor completion of the infu	to evidence the IV line had mal saline as ordered at the sion. The note states, 2210 [10:10 PM]. Flushed			

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
,	o. com.zomon	is Entri 101 til ott 100 til se i i i i i i i i i i i i i i i i i i	A. BUILDING: _	A. BUILDING:		
		003563	B. WING		R 01/04/2016	
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HEALTHS	SET		EBRON AVE LLE, IN 47714			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVED T	D BE COMPLET	E
{N 522}	the Benadryl and nun administered at 3:35 3:35 PM. The SN fail cream had been appl the port. The note failed been flushed with nor completion of the infu "Infusion completed. Port deaccessed." G. A SN visit note the Benadryl and nun administered at 7:40 accessed at 8:15 AM the numbing cream h to accessing the port. The note failed been flushed with nor completion of the infu "Infusion finished. Flushed been flushed with nor completion of the infu "Infusion finished. Flushed port." H. The plan of call skilled nurse to "perforder." (A respiratory rapidly inflates and deand is used to break the lungs.) SN visit notes, 11-23-15, 11-25-15, 12-15-15, 12-16-15	dated 12-22-15 evidenced abing cream had been PM and the port accessed at led to ensure the numbing ied 1 hour prior to accessing to evidence the IV line had mal saline as ordered at the ision. The note states, Flushed with 5 ml heparin. It dated 12-29-15 evidenced abing cream had been AM and port had been applied 1 hour prior to evidence the IV line had mal saline as ordered at the ision. The SN failed to ensure ad been applied 1 hour prior to evidence the IV line had mal saline as ordered at the ision. The note states, ushed port with 5 ml heparin. The included an order for the order to the included an order for the order to evidence the included an order for the order to evidence and secretions in dated 11-18-15, 11-20-15, 1-27-15, 11-30-15, 12-11-15, 8-15, 12-11-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 12-14-15, 11-21-15, 11-	{N 522}	DEFICIENCY)		

Indiana State Department of Health

STATE FORM 6899 CA5Q12 If continuation sheet 6 of 20

Indiana State Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		l R	
		003563	B. WING	B. WING		4/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
HEALTHS	FT	955D S HE	BRON AVE			
EVANSVIL		LE, IN 47714		Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{N 522}	Continued From page	e 6	{N 522}			
	SN had performed the	e vest therapy.				
	care established by the certification period 12 of care indicated home to be provided 5 time times per week for 1 of 1 week and 6 times per plan of care included (SN) to "perform dress week" to the left ischewound care orders stem with saline wound clesserile Q-tips apply Sapack with 4 x 4s and apply Calmoseptine cedges and apply skin	mber 2 included a plan of the physician for the 1-10-15 to 2-7-16. The plan we health aide services were so per week for 1 week, 8 week, 4 times per week for er week for 6 weeks. The orders for the skilled nurse sing changes 3 times a um [sic] and cocyx [sic]. The ate, "Cleanse wound beds anser soaked 4 x 4s, using antyl to wound beds and Kerlix. Using sterile Q-tips, bintment around wound prep to outer skin areas 3D pads and secure with				
		sian order dated 12-16-15 sing was to be applied to the f the Santyl.				
	B. The record evidenced home health aide visits had been provided only 4 times per week the second week and only 2 times per week the third and fourth weeks, instead of 8 times per week as ordered by the physician.					
	evidence the SN had	dated 12-18-15 failed to applied the Calmoseptine wound edges as ordered by				
	evidence the SN had	dated 12-24-15 failed to applied the silver dressing ordered by the physician.				

Indiana State Department of Health

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			D WING		R
		003563	B. WING		01/04/2016
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
HEALTHS	ET		BRON AVE LE, IN 47714		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{N 522}	Continued From page	2 7	{N 522}		
	3. Clinical record nur as a 69 year old with of the right forearm at obstructive pulmonary heart failure. The recestablished by the phyperiods 10-22-15 to 12-18-16. The plans of weight once a week a loss of 2 lbs within a victange to Rt [right] loforearm, Rt forearm v. A. SN visit notes, 12-7-15, 12-9-15, 12-12-18-15, 12-22-15, 12-12-18-15, 12-22-15, 12-12-18-15, 12-22-15, 12-12-18-15, 12-22-15, 12-12-18-15, 12-22-15, 12-12-18-15, 12-22-15, 12-12-18-15, 12-22-15, 12-12-18-15, 12-12-15, 12-12-15, 12-15	mber 3 identified the patient diagnoses of open wounds and right leg, COPD (chronic y disease), and congestive for included plans of care ysician for the certification 2-20-15 and 12-21-15 to for care state, "SN to obtain and notify MD of a gain or week. SN to do dressing wer leg, Lt [left] lower leg, Lt younds." dated 12-2-15, 12-4-15, 11-15, 12-14-15, 12-30-15 SN had obtained the y of the visits.			
		2-23-15, and 12-30-15 wound care had been ot's left lower leg.			
		was unable to provide any tion and/or information 6 at 3:00 PM.			
	Treatment (Care)/Cha	ated "Physician's Plan of ange Orders" policy number ency will provide ent with the plan of care."			
{N 524}	410 IAC 17-13-1(a)(1) Patient Care	{N 524}		
	of care shall:	As follows, the medical plan consultation with the home			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		003563	B. WING		R 01/04/2	016
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HEALTHS	ET		EBRON AVE LLE, IN 47714			
0/0.15	OUR MADE VIOLATEMENT OF DEFINITION			PROVIDER'S PLAN OF CORRECTIO	N	0/5)
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE C	(X5) COMPLETE DATE
{N 524}	Continued From page	e 8	{N 524}			
	health agency staff. (B) Include all service service is being provice. (B) Cover all pertiner. (C) Include the follow. (ii) Mental status. (iii) Types of service. (iii) Frequency and. (iv) Prognosis. (v) Rehabilitation p. (vi) Functional limita. (vii) Activities permit. (viii) Nutritional requi. (ix) Medications an. (x) Any safety mea. injury. (xi) Instructions for.	es to be provided if a skilled ded. In diagnoses. Ving: es and equipment required. duration of visits. otential. ations. ted. rements. d treatments. asures to protect against timely discharge or referral. ties specifying length of				
	failed to ensure plans individualized and spoin 2 (#s 1 and 3) of 3 The findings include: 1. Clinical record nur care established by the certification period 11 of care included an or "perform vest treatment vest is a garment that around the wearer and mucous and secretion."	ew and interview, the agency of care included ecific orders for treatments records reviewed. The physician for the 17-15 to 1-15-16. The plan of the skilled nurse to ent per order." (A respiratory trapidly inflates and deflates				

Indiana State Department of Health

STATE FORM 6899 CA5Q12 If continuation sheet 9 of 20

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SSSD S HEBRON AVE EVANSVILLE, IN 47714 PROVIDER'S HAN OF CORRECTION SOUTHWAY STATEMENT OF SEPCIAL COST THE STREET ADDRESS, CITY, STATE, ZIP CODE SSSD S HEBRON AVE EVANSVILLE, IN 47714 PROVIDER'S HAN OF CORRECTION SEGLA ACROST OR I.S. IDENTIFY NA. INFORMATION) [SCRIPTION SOUND IS CONTINUED IN INFORMATION) (N 524) Use of the respiratory vest. The plan of care included an order for heparin to be used as a flush after the influsion of an intravenous medication. The plan of care states, "Heparin 5 ml [milliter] IV, [Intravenous] post influsion following 10 cc [cubic centimeters] flush of 0.9% NaCl [sodium chloride]. The order failed to include the specific strength (number of units per millitiler) of the heparin. 2. Clinical record number 3 identified the patient as a 69 year old with diagnoses of open wounds of the right forearm and right leg, COPD (chronic obstructive pulmonary disease), and congestive heart failure. The record included a plan of care established by the physician for the certification period 12-21-15 to 2-18-16. The plan of care states, "SN to do dressing change to Rt (right) lower leg. Lt [left] lower leg. Lt [left] lower leg. Lt [forearm, Rt forearm wounds." A. The follow-up comprehensive assessment dated 12-16-15 failed to evidence an assessment of a wound on the patient's left leg. B. SN visit notes, dated 12-16-16, 12-18-15, 12-22-15, 12-22-15, 12-23-15, and 12-30-15 failed to evidence any wound care had been provided to the patient's left lower leg. 3. The administrator was unable to provide any additional documentation and/or information when asked on 1-4-16 at 3:00 PM.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 73P CODE #REALTHSET SSSO S HEBRON AVE EVANSVILLE, IN 47714 CANDIDATE PROVIDERS IN A 17714 CANDIDATE PROVIDERS IN A 17714 CANDIDATE PROVIDERS IN A 17714 CANDIDATE PROVIDERS IN A 17714 CANDIDATE PROVIDERS IN A 17714 CANDIDATE PROVIDERS IN A 177	7.1.12 . 2.1.1	5. GG.W.EG.1.G.1.	152.11.11.10.11.10.11.10	A. BUILDING: _	A. BUILDING:	
MEALTHSET SUMMARY STATEMENT OF DEFICIENCIES N 47714			003563	B. WING		
CAMPIDED SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCIES PREFIX REGULATORY OR LSC DESCRIPTIVES ON THE REGULATOR OR LSC DESCRIPTIVES ON THE REGULATORY OR LSC DESCRIPTIVES ON THE REGULATION OF CROSS REFERENCE OF THE REGULATORY OR LSC DESCRIPTIVES ON THE	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
CA1-ID PIEER PRODUCTE PIECE PRODUCTE PRODUC	HEALTHS	ET				
use of the respiratory vest. The plan of care included an order for heparin to be used as a flush after the infusion of an intravenous medication. The plan of care states, "Heparin 5 ml [millitler] V [intravenous] post infusion following 10 cc [cubic centimeters] flush of 0.9% NaCl [sodium chloride]. The order failed to include the specific strength (number of units per millitler) of the heparin. 2. Clinical record number 3 identified the patient as a 69 year old with diagnoses of open wounds of the right forearm and right leg. COPD (chronic obstructive pulmonary disease), and congestive heart failure. The record included a plan of care established by the physician for the certification period 12-21-15 to 2-18-16. The plan of care states, "SN to do dressing change to Rt [right] lower leg, Lt [left] lower leg, Lt forearm, Rt forearm wounds." A. The follow-up comprehensive assessment dated 12-16-15 failed to evidence an assessment of a wound on the patient's left leg. B. SN visit notes, dated 12-16-15, 12-18-15, 12-22-15, 12-23-15, and 12-30-15 failed to evidence any wound care had been provided to the patient's left lower leg. 3. The administrator was unable to provide any additional documentation and/or information when asked on 1-4-16 at 3:00 PM.	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE COMPLETE
4. The agency's undated "Physician's Plan of Treatment (Care)/Change Orders" policy number III-19 states, "The physician's plan of treatment (Medical Plan of Care) is an individualized plan	{N 524}	use of the respiratory The plan of care in to be used as a flush intravenous medication. "Heparin 5 ml [millilite infusion following 10 of 0.9% NaCl [sodium to include the specific per milliliter) of the her. 2. Clinical record numes a 69 year old with of the right forearm an obstructive pulmonary heart failure. The recestablished by the phyperiod 12-21-15 to 2-states, "SN to do dress lower leg, Lt [left] lower forearm wounds." A. The follow-up of dated 12-16-15 failed of a wound on the particular of a wound on the particular of a wound the patient's left lower 3. The administrator additional documenta when asked on 1-4-10. The agency's unda Treatment (Care)/Challi-19 states, "The physical of the patient's left of the property in the physical of the property is unda the patient's left lower 3. The agency's unda Treatment (Care)/Challi-19 states, "The physical of the property is unda the patient's left lower 3. The agency's unda the patient's left lower 3. The physical patient is a fluid to the patient's left lower 3. The physical patient is a fluid to the patient's left lower 3. The physical patient is a fluid to the patient's left lower 3. The physical patient is a fluid to the patient's left lower 4. The physical patient is a fluid to the patient's left lower 4. The physical patient is a fluid to the	ncluded an order for heparin after the infusion of an on. The plan of care states, er IV [intravenous] post oc [cubic centimeters] flush on chloride]. The order failed of strength (number of units eparin. Imber 3 identified the patient diagnoses of open wounds and right leg, COPD (chronic by disease), and congestive for included a plan of care exprised for the certification 18-16. The plan of care exprised for the certification 18-16. The plan of care exprised for the certification 18-16. The plan of care expressing change to Rt [right] er leg, Lt forearm, Rt comprehensive assessment assessment to evidence an assessment tient's left leg. dated 12-16-15, 12-18-15, and 12-30-15 failed to care had been provided to r leg. was unable to provide any and/or information 6 at 3:00 PM. ated "Physician's Plan of ange Orders" policy number sysician's plan of treatment	{N 524}		

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STATE FORM 6899 CA5Q12 If continuation sheet 10 of 20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED			
			A. BUILDING:			
		003563	B. WING		R 01/04/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HEALTHS	ET	955D S HEI				
			LE, IN 47714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	ſΕ
{N 524}	Continued From page	: 10	{N 524}			
	therapist who establis current assessment o orders on the plan of diagnosis and must be	nce from the nurse and/or the plan based upon the f the client Physician's treatment shall relate to the e considered reasonable ent for that diagnosis."				
N 527	410 IAC 17-13-1(a)(2) Patient Care	N 527			
	promptly alert the per- medical component o	The health care ne home health agency shall son responsible for the f the patient's care to any a need to alter the medical				
	staff failed to notify the	t as evidenced by: ew and interview, agency e physician of a change in eatus in 1 (#3) of 3 records				
	The findings include:					
	as a 69 year old with of the right forearm are obstructive pulmonary heart failure. The recestablished by the phyperiod 12-21-15 to 2-	nber 3 identified the patient diagnoses of open wounds and right leg, COPD (chronic vidisease), and congestive ord included a plan of care ysician for the certification 18-16. The plan of care ssing change to Rt [right] er leg, Lt forearm, Rt				
	-	omprehensive assessment to evidence an assessment ient's left leg.				

Indiana State Department of Health

STATE FORM 6899 CA5Q12 If continuation sheet 11 of 20

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		003563	B. WING		R 01/04/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	,
HEALTHS	ET		HEBRON AVE		
	OLIMANA DV. OT		/ILLE, IN 47714	DROVIDEDIO DI ANI GE CORDECTI	DV.
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
N 527	Continued From page	e 11	N 527		
	12-22-15, 12-23-15, a evidence any wound the patient's left lower 2. The administrator	dated 12-16-15, 12-18-15, and 12-30-15 failed to care had been provided to r leg. stated, on 1-4-16 at 3:15 the left leg] may have been			
	Treatment (Care)/Cha	ated "Physician's Plan of ange Orders" policy number certification of physician's include: Changes in client's cial condition."			
{N 537}	410 IAC 17-14-1(a) S	cope of Services	{N 537}		
	provide nursing service	home health agency shall ces by a registered nurse or urse in accordance with the as follows:			
	treatments, and servi				
	The findings include:				
	as a 14 year old pedia Syndrome, a genetic parts of the body, incl				

Indiana State Department of Health

STATE FORM 6899 CA5Q12 If continuation sheet 12 of 20

Indiana State Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE STREET ADDRESS, CITY, STATE, 2IP CODE SOB SHEBRON AVE EVANSVILLE, IN 47114 SUMMARY STATEMENT OF DESCRIPTIONS (EACH DEPRICENCY MUST SE PRECEDED BY PILL PREPAX TAG CONTINUED FROM DRIVE SECULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER OR AND TAGE (IN 537) Continued From page 12 included a plan of care established by the physician for the certification period 11-17-15 to 1-15-16. The plan of care states, SN (skilled nurse) to instruct PCG (patient caregiver) to administer Benadryl 25 mg (milligrams) via G-tube (gastinostomy tube) 30 to 60 minutes prior to infusion. SN to apply or instruct PCG to apply Emila cream [numbing medication] or LIMA! [7] cream one hour prior to accessing port SN to flush IV (Intravenous) line with 10 mil NS (normal saline), then 5 ml heparin, and deaccess port [remove needle].* A. A. SN visit note dated 11-20-15 evidenced the Benadryl and numbing cream had been administered at 3.35 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port per the physician's order. The note failed to evidence the IV line had been flushed after the infusion had been completed in accordance with the physician's order. The note states. "Infusion finished at 2150 [9:50 PM], Flushed with 5 ml heparin port deaccessed at 2151." The note failed to evidence the IV line had been deaccessed at 2151." The note failed to evidence the IV line had been flushed with normal saline per the physician's order.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 955D S HEBRON AVE EVANSVILLE, IN 47714 Maj ID PREPRIX SUMMARY STATEMENT OF DEFICIENCIES PROPERTY RECOULTION OF DEFICIENCY MUST BE PRECEDED BY PLUL PREPRIX RECOULTION OF CORRECTION PROPERTY RECOULTION OF CORRECTION RECOULTION OF CORRECTION OF CORRECTION RECOULTION OF CORRECTION OF CORRECTION RECOULTION OF CORRECTION OF CORR			A. BOILDING.	A. BOILDING.		?	
HEALTHSET O(A)10 SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MATTER NATT14			003563	B. WING		1	
CALLER C	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CM ID PREFIX IRACI DENTIFICIANCES PREFIX IRACI DENTIFICATION SHOULD BE PREFIX TAB PROVIDERS PLAND F CORRECTION COMPLETED AND TAB PROVIDERS PLAND F CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	HEALTHS	ET					
included a plan of care established by the physician for the certification period 11-17-15 to 1-15-16. The plan of care states, "SN [skilled nurse] to instruct PCG [patient caregiver] to administer Benadryl 25 mg [milligrams] via G-tube [gastrostomy tube] 30 to 60 minutes prior to infusion. SN to apply or instruct PCG to apply Emla cream [numbing medication] or LMX4 [?] cream one hour prior to accessing port SN to flush IV [intravenous] line with 25 ml [milliliters] NaCl [sodium chloride] at 40 ml per hour post infusion then flush line with 10 ml NS [normal saline], then 5 ml heparin, and deaccess port [remove needle]." A. A SN visit note dated 11-20-15 evidenced the Benadryl and numbing cream had been administered at 3:35 PM. m ESN failed to ensure the numbing cream had been accessed at 3:35 FM. The SN failed to ensure the numbing cream had been physician's order. B. A SN visit note dated 11-25-15 evidenced the Benadryl and numbing cream had been administered at 4:35 PM and the port had been administered at 4:35 PM and been accessed at 5:10 PM. The SN failed to ensure the numbing cream had been accessed at 3:51 PM. The SN failed to ensure the numbing cream had been accessed at 5:10 PM. The SN failed to ensure the numbing cream had been accessed at 5:10 PM. The SN failed to ensure the numbing cream had been completed in accordance with the port had been completed in accordance with the physician's order. The note failed to evidence the IV line had been completed in accordance with the physician's order. The note states, "Infusion finished at 2:150 [9:50 PM]. Flushed with 5 ml heparin port deaccessed at 2:15." The note failed to evidence the IV line had been flushed at 2:150 [9:50 PM]. Flushed with 5 ml heparin port deaccessed at 2:15." The note failed to evidence the IV line had been flushed with normal	PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
C. A SN visit note dated 12-1-15 evidenced	{N 537}	included a plan of car physician for the certi 1-15-16. The plan of nurse] to instruct PCC administer Benadryl 2 G-tube [gastrostomy to infusion. SN to ap Emla cream [numbing cream one hour prior flush IV [intravenous] NaCl [sodium chloridi infusion then flush lin saline], then 5 ml hep [remove needle]." A. A SN visit note the Benadryl and nun administered at 3:05 been accessed at 3:3 ensure the numbing of hour prior to accessir physician's order. B. A SN visit note the Benadryl and nun administered at 4:35 accessed at 5:10 PM the numbing cream h to accessing the port The note failed been flushed after the completed in accorda order. The note state [9:50 PM]. Flushed w deaccessed at 2151. evidence the IV line h saline per the physici	re established by the fication period 11-17-15 to care states, "SN [skilled 6] [patient caregiver] to 25 mg [milligrams] via tube] 30 to 60 minutes prior ply or instruct PCG to apply g medication] or LMX4 [?] to accessing port SN to line with 25 ml [milliliters] e] at 40 ml per hour post e with 10 ml NS [normal parin, and deaccess port arin, and deaccess port with 40 ml NS [normal parin, and been pM and that the port had been pM and the port per the dated 11-25-15 evidenced and bing cream had been applied 1 mg the port per the dated 11-25-15 evidenced and been pM and the port had been applied 1 hour prior per the physician's order. Ito evidence the IV line had a infusion had been ance with the physician's es, "Infusion finished at 2150 with 5 ml heparin port to the function of the prior per the flushed with normal and sorders.	{N 537}	DE. KALINOTI)		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		003563	B. WING		R 01/04/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
HEALTHS	ET		BRON AVE LE, IN 47714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{N 537}	administered at 4:20 4:55 PM. The SN fail cream had been appl the port. D. A SN visit note the Benadryl and nun administered at 3:35 4:05 PM. The SN fail cream had been appl the port. The note failed been flushed after the completed in accorda E. A SN visit note the Benadryl and nun administered at 4:55 5:35 PM. The SN fail cream had been appl the port. The note failed been flushed with nor completion of the infu "Infusion complete at [with] 5 ml heparin. E F. A SN visit note the Benadryl and nun administered at 3:35 3:35 PM. The SN fail	anbing cream had been PM and the port accessed at ed to ensure the numbing ited 1 hour prior to accessing dated 12-8-15 evidenced are to ensure the numbing cream had been PM and the port accessed at ed to ensure the numbing ited 1 hour prior to accessing to evidence the IV line had a infusion had been nuce with physician orders. dated 12-15-15 evidenced are to ensure the numbing cream had been PM and port accessed at ed to ensure the numbing ited 1 hour prior to accessing to evidence the IV line had are to evidence the IV line had are to ensure the numbing ited 1 hour prior to accessing to evidence the IV line had are saline as ordered at the sion. The note states, 2210 [10:10 PM]. Flushed	{N 537}		
	been flushed with nor	to evidence the IV line had mal saline as ordered at the sion. The note states			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
711012111	or contribution	IDENTIFICATION NOMBER.	A. BUILDING:			
		003563	B. WING		01/0	4/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HEALTHS	ET		BRON AVE			
			LE, IN 47714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{N 537}	Continued From page	: 14	{N 537}			
	"Infusion completed. Port deaccessed."	Flushed with 5 ml heparin.				
	the Benadryl and num administered at 7:40 a accessed at 8:15 AM.	dated 12-29-15 evidenced hising cream had been AM and port had been The SN failed to ensure ad been applied 1 hour prior				
	The note failed to evidence the IV line had been flushed with normal saline as ordered at the completion of the infusion. The note states, "Infusion finished. Flushed port with 5 ml heparin. Deaccessed port."					
	H. The plan of care included an order for the skilled nurse to "perform vest treatment per order." (A respiratory vest is a garment that rapidly inflates and deflates around the wearer and is used to break up mucous and secretions in the lungs.)					
	11-23-15, 11-25-15, 1 12-2-15, 12-7-15, 12- 12-15-15, 12-16-15, 1	15, failed to evidence the				
	care established by the certification period 12 of care indicated home to be provided 5 times times per week for 1 values and 6 times per plan of care included (SN) to "perform dress"	nber 2 included a plan of the physician for the 10-15 to 2-7-16. The plan e health aide services were so per week for 1 week, 8 week, 4 times per week for er week for 6 weeks. The orders for the skilled nurse sing changes 3 times a im [sic] and cocyx [sic]. The				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
	A. BUILDING:						
		003563	B. WING		01/0 ₄	4/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HEALTHS	ET	955D S H	EBRON AVE				
			LLE, IN 47714				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE	
{N 537}	Continued From page	e 15	{N 537}				
	wound care orders stawith saline wound clesterile Q-tips apply Sapack with 4 x 4s and apply Calmoseptine cedges and apply skin cover wounds with AE tape."	ate, "Cleanse wound beds anser soaked 4 x 4s, using antyl to wound beds and Kerlix. Using sterile Q-tips, bintment around wound prep to outer skin areas BD pads and secure with					
		sian order dated 12-16-15 sing was to be applied to the f the Santyl.					
	visits had been provide the second week and	denced home health aide ded only 4 times per week only 2 times per week the s, instead of 8 times per ne physician.					
	evidence the SN had	dated 12-18-15 failed to applied the Calmoseptine wound edges as ordered by					
	evidence the SN had	dated 12-24-15 failed to applied the silver dressing ordered by the physician.					
	as a 69 year old with of the right forearm at obstructive pulmonary heart failure. The recestablished by the ph periods 10-22-15 to 1 2-18-16. The plans of weight once a week at loss of 2 lbs within a very serior of the right of the plans	mber 3 identified the patient diagnoses of open wounds and right leg, COPD (chronic y disease), and congestive for included plans of care ysician for the certification 2-20-15 and 12-21-15 to f care state, "SN to obtain and notify MD of a gain or week. SN to do dressing wer leg, Lt [left] lower leg, Lt younds."					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R	
		003563	B. WING		01/04/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HEALTHS	ET		BRON AVE			
	OLUMAN DV OT		LE, IN 47714	DD0/4050/0 D/ AV 05 00DD507/0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
{N 537}	Continued From page	e 16	{N 537}			
N 541	12-7-15, 12-9-15, 12-12-18-15, 12-12-18-15, 12-22-15, 15 failed to evidence the patient's weight at any B. SN visit notes, of 12-7-15, 12-9-15, 12-12-18-15, 12-92-15, 15 failed to evidence any provided to the patient 4. The administrator additional documenta when asked on 1-4-10 for the attending physicial 410 IAC 17-14-1(a)(1) Rule 14 Sec. 1(a) (1)(are limited to therapy practice in the home Inurse shall do the foll (B) Regularly reevaluneeds. This RULE is not me Based on record revisitied to ensure update the patient of the shall do the foll (B) regularly reevaluneeds.	dated 12-2-15, 12-4-15, 11-15, 12-14-15, 12-14-15, 12-16-15, 12-23-15, and 12-30-15 / wound care had been at's left lower leg. was unable to provide any tion and/or information 6 at 3:00 PM. ated "Scope of Services" ates, "Professional nursing ormed in accordance with an's plan of treatment." (B) Scope of Services (B) Except where services only, for purposes of nealth setting, the registered owing: ate the patient's nursing t as evidenced by: ew and interview, the agency tes and revisions to the sements were complete in 2	N 541			
	The findings include:					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN			A. BUILDING:			
	003563		B. WING		R 01/04/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HEALTHS	ET		BRON AVE LE, IN 47714			
	QUILLEN OT					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPL	ETE.
N 541	Continued From page	2 17	N 541			
	Clinical record nur comprehensive assessment identifies that is "acute" and "ch secretions that "requi "suctioning necessary to evidence how ofter and how the patient to A. The assessment gastrostomy tube for feedings. The assess type of feedings and to day.	mber 1 included a follow-up asment dated 11-13-15. The athe patient has a cough pronic" with "thick, white" are suctioning" and y". The assessment failed to an the suctioning is required polerates the procedure. In identifies the patient has a mutrition and receives bolus asment failed to evidence the the number of feedings per				
	B. The assessment identifies the patient is unable to vocalize and makes eye contact. The assessment failed to evidence communication patterns and methods used to relate to the patient.					
		• •				
	comprehensive asses	nber 2 included a follow-up ssment dated 12-4-15. The evidence an assessment of his had been left blank.				
	performs in and out s assessment failed to	nt identifies the patient elf-catheterization. The identify the type of catheters int obtained, or any issues zation.				
	B. The assessme a "colostomy". The a evidence any detatils					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED	
	003563		B. WING		R 01/04/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HEALTHS	FT	955D S HI	BRON AVE			
TILALITIO		EVANSVII	LE, IN 47714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
N 541	Continued From page	e 18	N 541			
	evaluation of the patie	nt failed to evidence an ent's psychosocial status. sessment had been left				
		nt identified the patient has ment failed to evidence port.				
		was unable to provide any tion and/or information 6 at 3:00 PM.				
{N 542}	410 IAC 17-14-1(a)(1)(C) Scope of Services	{N 542}			
	Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.					
		ew and interview, the d to initiate a revision to the ss a change in the patient's				
	The findings include:					
	as a 69 year old with of the right forearm and obstructive pulmonary heart failure. The red established by the ph period 12-21-15 to 2-	mber 3 identified the patient diagnoses of open wounds and right leg, COPD (chronic y disease), and congestive ford included a plan of care ysician for the certification 18-16. The plan of care ssing change to Rt [right]				

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STATE FORM 6899 CA5Q12 If continuation sheet 19 of 20

Indiana State Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X		(X3) DATE SURVEY COMPLETED			
			A. BUILDING.		R			
		003563	B. WING		01/04/2016			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HEALTHS	ET		EBRON AVE					
			LE, IN 47714					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE			
{N 542}	Continued From page	: 19	{N 542}					
	lower leg, Lt [left] lower forearm wounds."	er leg, Lt forearm, Rt						
		comprehensive assessment to evidence an assessment ient's left leg.						
	12-22-15, 12-23-15, a	care had been provided to						
		stated, on 1-4-16 at 3:15 he left leg] may have been						
	3. The agency's undated "Scope of Services" policy number III-2 states, "Skilled Nursing Services Professional nursing services shall be performed in accordance with the attending physician's plan of treatment and shall include but not be limited to: Assessment and regular reassessment of the nursing needs of the client throughout the course of care Notification of physician of client progress."							

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